Adult learning, professional autonomy and individual commitment

H. Pardell-Alentá [a,b]

ADULT LEARNING, PROFESSIONAL AUTONOMY AND INDIVIDUAL COMMITMENT

Summary. Development. *The concept of 'andragogy' is the basis of the adult education which is different from pedagogy in several aspects, particularly in the autonomy of the adult learner in choosing the educational programmes and the methodologies and sites in where learning occurs. This happens very often in the worksite. The professionals have to learn permanently during their active lives in order to maintain their competence updated. In this sense, continuing education correlates with continuing professional development, which is an attempt to enlarge the traditional domains of continuing education. Continuing education must be clearly differentiated from formal education, which is a requirement for granting professional degrees or titles. Very often it arises from the changing health needs and for this reason is necessary to avoid the institutionalization of continuing education programmes.* Conclusion. *Professional associations should be actively involved in providing and accrediting continuing education-continuing professional development programmes, because this involvement is an essential component of the professionals' self-regulation in the context of the current medical professionalism ideology. [REV NEUROL 2008; 46: 225-9]*
Key words. *Adult learning. Andragogy. Continuing medical education. Continuing professional development. Medical professionalism.*

INTRODUCTION

Adult learning is the conceptual basis of continuing medical education (CME), a field that is attracting increasingly more attention in the professional world of medicine.

The elements that differentiate adult learning (andragogy) from child and youth learning (pedagogy) are crucial to understand the essential characteristics of the former and to be able to plan and organise suitable educational programmes for practising physicians.

As we shall see, CME is intimately related to continuing professional development (CPD), another domain that has recently come to the fore in the professional world.

Equally important is the relation between adult education and the different areas of the regulation of the profession, and more particularly as far as self-regulation or shared regulation are concerned.

Finally, the substantial differences between formal education and CME will be discussed, and the hazards and risks of converting the latter into an institutionalised, programmed kind of education will be highlighted.

PEDAGOGY VERSUS ANDRAGOGY

The term 'pedagogy', which comes from the Greek *paidagōgeō*, has been defined as 'the art or science of teaching and educating children' [1]. By extension, the word is thus used to refer to education in general.

Nevertheless, since the 1970s and under the decisive influence of Knowles and his school of thought, the term 'andragogy' has been used to mean 'the science and art of helping adults to learn' [2-5].

As I have outlined elsewhere [6], autonomy is the essential feature of adult learning and it is focused on adults' capacity to think in a rational way, to reflect, to analyse evidence, to judge things for themselves, to get to know themselves and to be free to form and voice their own opinions.

If we transfer this autonomy to the field of education, it means that the adult is capable of learning in a self-guided manner that is based on four essential components, i.e. personal autonomy, the will and capacity to guide one's own learning, control over the educational setting and the independent learning process [7].

This idea of self-learning becomes crucial [8] and is linked to the process of reflection, which I will come back to later, and to the notion of life-long learning [9,10], one of the fundamental features of the most recent way of thinking of the medical profession [11]. Moreover, it is also very directly related to the communities of practice ideology, proposed by Wenger [12].

The motives that drive the adult to learn are manifold, but the primary interest is always to apply the newly acquired knowledge to their professional practice. Hence, the learning process is greatly enhanced if it is directly connected with their career. In addition to being related to the propositions put forward by Argyris and Schön, which I will come back to later, this also has to do with the concept of 'learning organisation', put forward by Senge to characterise organisations that are willing to combine life-long learning with the daily work [13].

Further, it should also be pointed out that adults learn in very different ways and each person prefers certain methods, depending on their cognitive style and their experience [14]. Likewise, it is worth highlighting the fact that, rather than necessarily taking place in formal educational settings, in such cases learning often (and even preferably) takes place in informal situations [15]. This represents a strong argument for emphasising the importance of the casual, multi-faceted nature of CME, as opposed to the claims by those who defend the need to regulate and institutionalise it.

To sum up what I have said until now, and following on from Bennett, the essential features of adult learning can be stated as follows [16]:

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- Learning is a capacity that adults display at any age.
- Said learning is usually self-directed.
- Individual experience plays a decisive role in it.
- Learning is oriented towards practice; adults learn voluntarily and choose what they want to learn.
- The more actively the individual is involved in the learning process, the more effective it is.
- The feedback process is a crucial part of this learning.
- The use of different types of learning varies depending on the stage of their career the individual currently finds him or herself in.
- Each adult learns in a different way and in different situations.
- The surer adults are about what they want, the more willing they are to modify their behaviour in order to learn.

And from the work by Knowles we can take the basic elements distinguishing the pedagogic and andragogic approaches to education [5]:

- In the pedagogic approach pupils are dependent, whereas in the andragogic line they are autonomous.
- Children have little or no experience, while adults possess a large amount of accumulated and differentiated experience.
- In the pedagogic approach willingness to learn is based on moving from one educational level to another, whereas in the case of adults it depends on their own needs.
- Learning in children focuses on topics or subject areas, while in adults it concentrates on problems.
- The motivation driving children to learn is influenced by external pressures, but in adults the motivation can be internal or external in varying proportions, depending on each case.

ADULT LEARNING AND CONTINUING PROFESSIONAL DEVELOPMENT

Traditional CME focused on updating the knowledge that had been acquired in the pre and postgraduate periods of education, as well as learning new knowledge that is generated hand in hand with scientific and technological progress.

As the emphasis has shifted to the different components of the individual pool of capabilities, rather than knowledge, it is becoming more and more frequent to hear speak of CPD [17]. This wider concept of CPD is a development on that of CME, with the incorporation of the skills, attitudes and behaviours that orientate professional practice as well as other fields that are not strictly related to clinical work, such as leadership, clinical management, teamwork, professionalism, communication and ethics, among others [18-20].

Within the context of CPD two key ideas must be emphasised: priority given to involvement of the individual, in addition to that of professional associations, on the one hand, and the professional's process of reflection, on the other.

This latter has its roots in the early claims by Schön in the 1980s [21,22], in which this researcher established the two ways professionals can think about their continued learning process; it can thus be based either in practice or on practice. A large part of this process of reflection takes place in casual, rather than formal, learning situations [23] and it is usually of an intuitive nature, which is precisely what essentially characterises the expert [24]. These conceptual premises have been taken as the foundation on which the 'portfolio' has recently been developed as an individual CPD tool.

As far as individual and professional involvement are concerned, there are a number of interesting points that need to be considered. On the one hand, it must be remembered that, within the conceptual framework of traditional CME, emphasis was placed on its role as part of the physician's ethical-professional duty. Yet, as they tend to work increasingly more frequently as employees of public and private health organisations, with trade unions playing a predominant part in things, at the same time the notion that CME is something that should be provided by employers in the workplace and during working hours has also become more widespread. It goes without saying that this conceptual shift is the cause of far-reaching repercussions within the medical profession, as I have analysed elsewhere [25,26].

Hence, when talking about replacing CME by CPD, we must insist on the fact that such professional development has to become the duty that each physician owes to their employer, to their professional association and, ultimately, to society itself [27,28]. It would make no sense at all to make the same mistake as has been made in developing the career in our country, where, generally speaking, this element of individual commitment has been largely neglected. If we are to introduce CPD as a step forward from traditional CME, we must inevitably start with its essential nature, first, as an individual commitment and, second, as a commitment by the corresponding professional organisation (that is to say, a scientific society or professional association).

In this regard, it must be pointed out that the role played by the professional medical associations is closely related to their responsibilities concerning self-regulation or, as it is now more commonly called, shared regulation of the profession. Indeed, at the present time, when the need for commitment and accountability to society is taking on an unquestionably more prominent role, professional medical associations must exercise their responsibility as regulating agents if they want to continue to enjoy social legitimacy. And CPD represents a field that is particularly suitable for carrying out this self-regulation, essentially by means of its two ratifying initiatives, i.e. recertification and relicensure/recollegiation, this latter being the term used in the Spanish context [29-32].

Lastly, going back to the individual commitment component considered earlier and contextualising it within the framework of work in complex learning organisations which I discussed above, it is interesting to highlight the conceptual developments put forward by Argyris [33-35]. These proposals allow this professional commitment and its active integration within the workplace to become compatible with the management of such organisations, without either of the parties being adversely affected by the dysfunctions that, otherwise, appear daily as a consequence of the incapacity to resolve the clash between the bureaucratic organisation (which tends towards homogenisation) and the professional ideology (which tends towards a discretional nature).

SHOULD CONTINUING MEDICAL EDUCATION BE FORMAL?

It is unanimously accepted that CME is mostly casual and arises at the same time as the different initiatives undertaken in answer to different situations, which, in many cases, makes complete sense. On the other hand, as we saw earlier, adult learning is not always (or even usually) formal, since it often takes place in an informal way within the professional work setting.

Formal, structured education is the best suited for educational formats that end with a qualification being awarded (whether it is basic, a specialisation or equivalent). Thus, it can be scheduled for long-lasting cycles (annual or longer) and is usually provided within institutions that are specifically dedicated to the educational activities included in such formats. Such is the case of university education geared towards earning a degree in medicine, postgraduate education to qualify as a specialist or the university formats of the traditional master's degrees or their equivalents.

CME, on the other hand, usually appears to meet the needs of each moment by attempting to provide knowledge, skills and attitudes that can be used to cope with new challenges in health care, which their formal basic and specialised education has left physicians insufficiently prepared to deal with.

As an example we can consider the appearance of a parasitic disease in an immigrant population of Africans living somewhere in our country. The doctors who have to deal with the outbreak are not sufficiently well prepared to cope with it because they have not seen cases of this disease on a regular basis and what they learnt in their pre and postgraduate training is now obsolete. Can there be any doubt that arranging a CME event for these physicians on the diagnosis and treatment of this parasitic disease, however infrequently it may be held, will be a valuable strategy to ensure patients receive the best possible health care? And, yet, the educational format does not have to be formal or last a long time or be carried out in specific educational institutions; on the contrary, it can be arranged by a professional collective that is aware of the emerging needs of its members and is motivated enough to ensure the success of the educational activity.

To claim, as has been stated by some, that high-quality training can only be guaranteed by means of formal programmes given in specifically approved educational institutions is very dangerous and takes us back to the situation that existed in Eastern European countries for decades. All these countries had central educational institutions that all physicians in the country had to regularly attend if they wanted to maintain their status and their license to practise. From experience we know that such institutions were more like bureaucratic institutions that enabled the State to control the profession. The training was of rather dubious quality and did little or nothing to really help maintain the professional competency of physicians; instead, it was aimed at indoctrinating them in the political-health care ideology of the government in power at each moment.

It is obvious that this discussion between casual and formal CME is closely related to the vision concerning the regulation of the medical profession. Those who view CME as a predominantly casual educational proposal base their argument on the principle that the profession, through its own associations, has to further its self-regulation (shared regulation), lead the way as far as the CME issue is concerned, and choose the educational programmes that are best suited to each sector and each moment and situation. They therefore defend the claim that the educational proposals should be provided by such associations using traditional methods (congresses, scientific meetings, courses that require the pupils' attendance) or the more recent ones that take advantage of the new technologies (e-learning activities, distance learning with educational materials, and so forth).

In contrast, those who see CME as an institutional educational proposal usually base their themselves on the idea that the physician is yet another human resource in the system –a public health service employee– who must be provided with the CME that the employer decides is necessary, the aim being to provide training that will enable the professional to offer what is considered to be the highest quality service. It should therefore come as no surprise that there is an increasingly more frequent tendency to resort to training in educational institutions such as public health, quality or training institutes, or whatever they might be called by the different regional health authorities that utilise both the traditional and the latest educational formats.

It goes without saying that this latter posture is the one that is usually adopted by most of the autonomic health care systems in our country and their corresponding accreditation commissions for continuing health education. The former, in contrast, is the one that predominates in the professional world, basically at the level of scientific societies and official medical associations.

All this represents a real challenge for the profession and for the public autonomic bodies involved in providing CME for 'their' physician employees, for the autonomic accrediting commissions and, more especially, for the Spanish Commission for Continuing Education for Health Professionals, which was restructured in August 2007 [36]. The professional world's presence on this commission is still little more than testimonial, its ex-officio members being the autonomic governments, which highlights the idea that physicians are considered to be mere employees of the public health services.

CONCLUSIONS

Taking all the above into consideration, it is obvious that we are now at a really decisive moment and to overcome it we are going to need a clear vision of the future and large doses of generosity and commitment.

Many of the important questions were already raised in a previous article, in which we outlined what we sensed to be the predominant tendencies in the field of CME and its accreditation [37]. Many of those intuitive feelings have gradually been seen to come true and, today, we now face the challenge of solving the dilemmas posed by the Spanish *Ley de Ordenación de las Profesiones Sanitarias* (Health Professions Regulation Act). This law envisages CME as a right and a duty for professionals and allows for a great deal of overlapping between the professional career and CPD, which leads to a great deal of confusion. If we examine the statement of CME as a right in more depth, we are inevitably heading towards the field of trade union claims, whereas if we look at it as a duty, then we find ourselves in the domain of professional commitment.

Obviously this dilemma is no trivial matter for the medical profession because to a large extent its future as a profession depends on whether a suitable solution is found or not, as we have examined in detail elsewhere [38]. Indeed, if we choose to follow the path of CME and CPD as an ethical-professional duty, in the context analysed by Gracia [39], then the profession can look towards a relatively bright future, and especially so if it goes further into the field of self-regulation and shared regulation in a sensible, cautious way that has been agreed on with the other social agents. If, in contrast, we decide to follow a policy of making demands (and even outright confrontation), then its future as a profession in the strictest sense of the word will be seriously compromised and the outlook is one of increased 'deprofessionalisation', with everything that such a process entails [26].

Everything seems to indicate that the most sensible thing would be to establish a balance between the two options, which should be complemented with professional initiatives that have the commitment of governments, in their role as social regulatory agents; such initiatives must be focused on an explicit wish to advance in the field of shared professional regulation. This explicit commitment by professional agents should be accompanied by reasonable attitudes from governments, which will tend to draw a clear distinction between their respective roles as employers and regulators, since it is precisely the overlap between these two functions that gives rise to so many problems.

From the professional side (both the medical associations and scientific societies) there seems to be a certain degree of willingness to progress along this path, which must be marked by two unavoidable criteria: a firm commitment and a clear independence. On the part of the regulatory agents and public employers, everything seems to indicate that they will be able to see quite clearly the advantages that derive from having an open mind towards shared regulation, as well as the serious risks that can result from having a closed view, in which the medical profession is seen as a workforce that is subject to a set of rules and regulations on occupation, which is directly related to the field of health care administration.

The fact is that an excessive degree of interventionism and legislative regulation already has its own limitations and drawbacks [40-42], and so socially complex tasks, such as those that are usually performed by a profession like the medical profession, cannot be judged using simple normative standards without making clumsy, mistaken judgments and doing irreparable damage [43]. It is true that self-regulation has its advantages and disadvantages, but viewed in perspective, there can be no doubt that the former outnumber the latter by far. Consequently, there must be a determined drive for its implementation, provided this is done within a framework of shared regulation based on expertise and efficiency. In this process, three types of commitment must be present, i.e. to the members of the self-regulated collective, to the population and to the government [44].

From the fields of the sociology of professions and of the organisation of health care systems, it has been made clear that a non-committed medical profession is the best way to ensure the failure of any health care system. If, as can be deduced from the latest surveys conducted among the population, society holds the Spanish medical profession in high esteem and this profession, it seems, displays increasing stronger attitudes of wishing to be dissociated from the public health care systems, it seems clear that something must be done if we want to maintain the quality of our health care system(s). And to achieve this we need the commitment of everyone, i.e. physicians, employers, governments and, of course, patients and the entire population.

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FORMACIÓN DE ADULTOS, AUTONOMÍA PROFESIONAL Y COMPROMISO INDIVIDUAL

Resumen. Desarrollo. *La formación de adultos tiene sus raíces conceptuales en la noción de 'andragogía' y se diferencia de la pedagogía en múltiples aspectos, el más relevante de los cuales es la autonomía en la selección de lo que se quiere aprender y en la forma y momento en que se hace, y generalmente ocurre en el lugar de trabajo. El profesional debe aprender en todo momento a lo largo de su vida, como una manera de mantener actualizada su competencia. Y en este punto entronca con lo que hoy en día se denomina desarrollo profesional continuo, en un intento de ensanchar los límites tradicionales de la formación médica continuada. Ésta, por su parte, debe diferenciarse claramente de la formación reglada, que permite obtener titulaciones exigibles y con frecuencia surge al compás de las necesidades cambiantes del momento. Por ello, debe huirse de su institucionalización y mantener su carácter oportunista, como elemento genuino.* Conclusión. *Las asociaciones profesionales deben involucrarse más activamente en la provisión y la acreditación de la formación médica continuada-desarrollo profesional continuo, como un componente esencial de su autorregulación que emana del ideario del profesionalismo médico actual. [REV NEUROL 2008; 46: 225-9]*

Palabras clave. *Andragogía. Desarrollo profesional continuo. Formación de adultos. Formación médica continuada. Profesionalismo médico.*